

11592

CERTIFICATE OF DEATH

Reg. Dist. No. 193

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause		(a) Complete Heart Block		30 hrs ?	
Antecedent cause(s)		(b) Chronic Myocarditis		15 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c) Thyrotoxicosis due to toxic Goiter		15 yrs.	
II. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
October, 1936		Hypertrophic Thyroiditis		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1935, to Jan. 2, 1951, that I last saw the deceased alive on Jan. 2, 1951, and that death occurred at 10:15 P.m., from the causes and on the date stated above.

SIGNATURE P. J. [illegible] (Degree or title) ADDRESS [illegible] DATE SIGNED [illegible]

SIGNATURE *Anthony Grabbit*

M.D.

ADDRESS

Mt. Airy, Maryland

DATE SIGNED

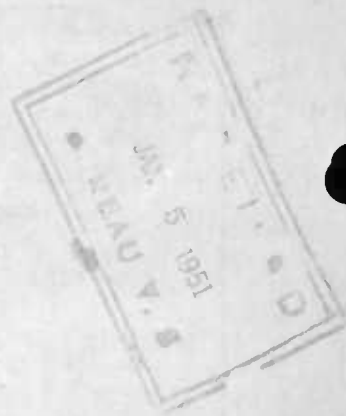
1/2/51

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<i>Removal</i>	<i>Jan - '51</i>	<i>Not'l. New. Park</i>	<i>Falls Church, Va.</i>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<i>1-2-51</i>	<i>E. Pearl Mercio</i>	<i>Wheatley Funeral Home</i>	<i>800 King St., Alexandria, Va.</i>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

6593

1. PLACE OF DEATH COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL, and give nearest town) <u>Ellicott City</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>St. Paul St.</u>		STREET ADDRESS (If rural, give location) <u>St. Paul Street</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>AVIS ROSELLA CRAMBLITT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 15th 1951</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Single</u>	8. DATE OF BIRTH <u>5/12/73</u>
9. AGE last birthday <u>77</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John L. Cramblitt</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Keith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>John Cramblitt - Ellicott City</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Cardiac Failure

INTERVAL BETWEEN ONSET AND DEATH

3 days

Antecedent cause(s)

(b)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

Myocardial Cardio-Vascular Disease4 months

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

None

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

m.

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 Sept., 1950, to 15 Jan., 1951, that I last saw the deceasedalive on 14 Jan., 1951, and that death occurred at 7:40 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William B. JansawayM.D.Ellicott City, Md.1/15/51

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

1-17-51John B. LongmanCarlton Sons, Ellicott City, Md.

720 826

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1906 Pine Ave</u>		STREET ADDRESS (If rural, give location) <u>1906 Pine Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Eleanor</u>	(Middle) <u>A.</u>	(Last) <u>Eberwein</u>
4. DATE OF DEATH	(Month) <u>Jan</u>	(Day) <u>18</u>	(Year) <u>1951</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>10/5/1882</u>
9. AGE last birthday <u>68</u> yrs.		10. AGE last birthday <u>68</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Nurse</u>	
11. BIRTHPLACE (State or foreign country) <u>Carroll Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jacob Coppersmith</u>		14. MOTHER'S MAIDEN NAME <u>Eleanor Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mary Wadon 1906 Pine Ave, Elkridge</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) <u>Pulmonary atelectasis</u>	INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>
Antecedent cause(s) (b) <u>Recent operation for intestinal obstruction</u>	<u>2 wks.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)	

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition, Marasmus.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 16, 1951, to Jan. 18, 1951, that I last saw the deceased

alive on Jan. 18, 1951, and that death occurred at 11:42 P. m., from the causes and on the date stated above.

SIGNATURE Charles Tommasello M.D. ADDRESS 210 W. Lombard St. Baltimore DATE SIGNED

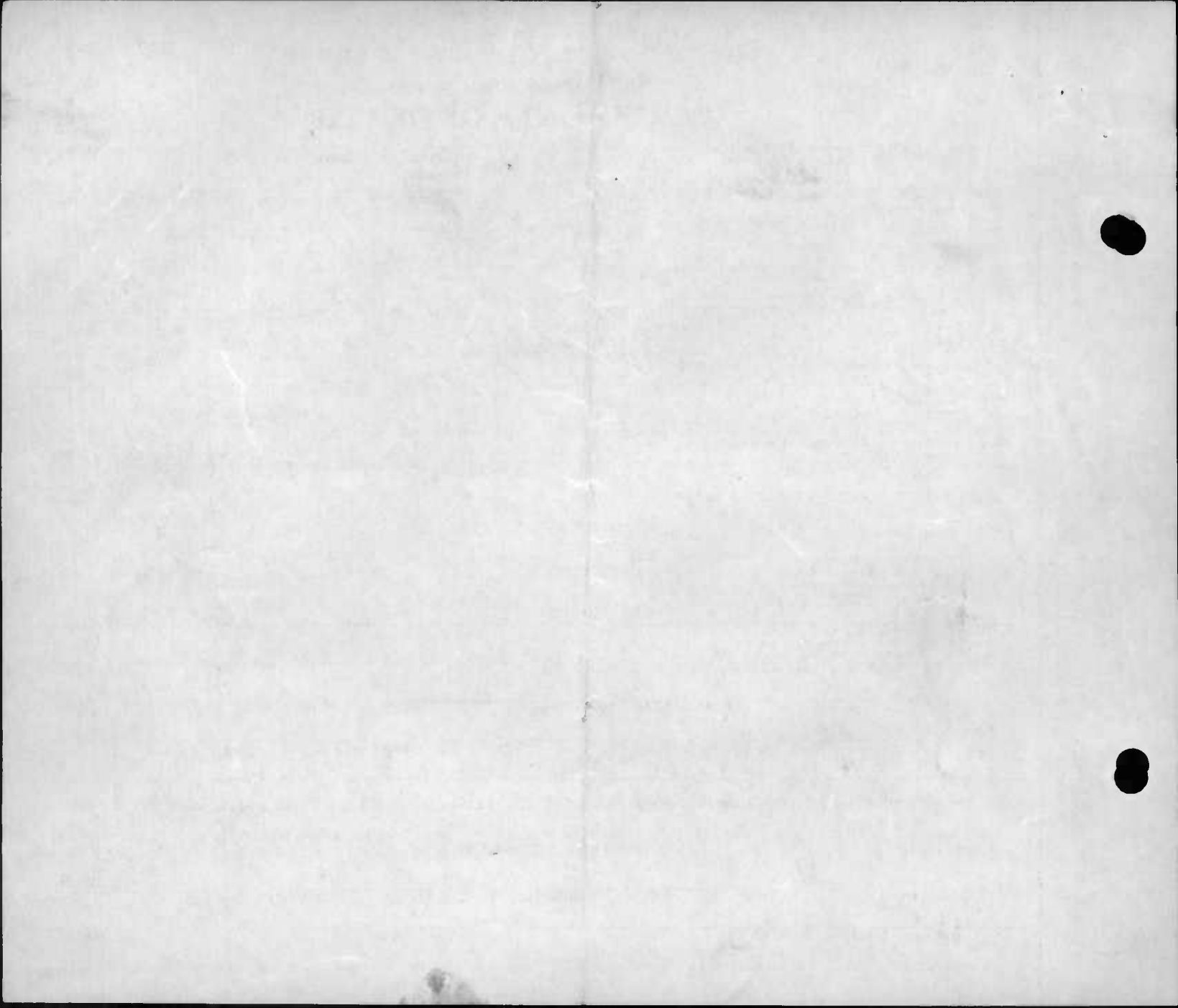
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>1/22/51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peter's</u>	LOCATION (City, town, or county) <u>Balto. Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>1/22/51</u>	REGISTRAR'S SIGNATURE <u>A. W. Hulse</u>	24. FUNERAL DIRECTOR <u>Wm. Cook Inc.</u>	ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

770VVV



MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 195

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville Rural</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Sykesville, R.F.D.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. Sykesville, Md.</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>WAUGH</u> (Middle) <u>MORSE</u> (Last) <u>GLASCOCK</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>January 4, 1951</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>Oct. 26, 1950</u>
9. AGE last birthday <u>2</u> yrs. <u>4</u> months <u>4</u> days		10. IF under 1 year If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Fredrick Waugh Glascock</u>		14. MOTHER'S MAIDEN NAME <u>Mary Louise Morse</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Mary L. Glascock</u>		<u>Sykesville Rural</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) Multiple congenital anomalies

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Coarctation of the aorta

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Stanley A. Deulachan M.D. 700 Fleet St., Baltimore 2, Md. January 5, 1951

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

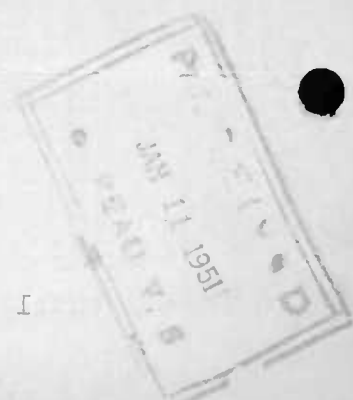
1-2-51John P. DeulachanF.C. Higinbotham, Ellicott City, Maryland

200260-27404
E. Paul Mercier

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH- COUNTY HOWARD MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN ELKRIDGE (RURAL) LENGTH OF STAY (in this place) 4 weeks HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MASSACHUSETTS COUNTY BERKSHIRE CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN PITTSFIELD STREET ADDRESS (If rural, give location) 22 POMEROY Avenue	
3. NAME OF DECEASED (Type or Print) SARAH ELIZABETH TALLMADGE HUMPHREVILLE		4. DATE OF DEATH JANUARY 15 1951	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH OCT. 23, 1978
9. AGE last birthday 72 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) CONNECTICUT		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES TALLMADGE		14. MOTHER'S MAIDEN NAME SHERWOOD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY No. NO	
17. INFORMANT AND ADDRESS MRS. GEORGE VAN B. SHRIVER, ELKRIDGE, MD.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
480.1 Immediate cause (a) Coronary Occlusion		Inst.
Antecedent cause(s) (b) arterio-sclerosis, generalized		1 yr.
94a Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) ✓		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION ✓	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) ✓ SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY ✓	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? th

22. I hereby certify that I attended the deceased from **Jan. 1, 1951**, to **Jan. 15, 1951**, that I last saw the deceased alive on **Jan. 14, 1951**, and that death occurred at **10-a** m., from the causes and on the date stated above.

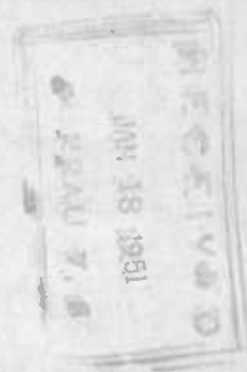
SIGNATURE **Frank Shipley, M.D., Savage, Md.** ADDRESS **116/51** DATE SIGNED **1/16/51**

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF JAN. 19, 1951	NAME OF CEMETERY OR CREMATORY WOOD LAND	LOCATION (City, town, or county) (State) STAMFORD, CONN.
DATE REC'D BY LOCAL REG. Jan 17 - 1951	REGISTRAR'S SIGNATURE E. B. Williams	24. FUNERAL DIRECTOR ADDRESS Dr. With. Donaldson, Laurel, Md.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

241 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Ellicott City</u> TOWN <u>Ellicott City</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bethany Road</u>			2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u> TOWN <u>Ellicott City</u> STREET ADDRESS (If rural, give location) <u>Bethany Road</u>		
3. NAME OF DECEASED (First) (Middle) (Last) <u>Susie Ireland</u>			4. DATE OF DEATH <u>1-14-51</u> 19 <u>51</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>1857</u>	9. AGE last birthday <u>94</u> yrs.	If under 1 year Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At home</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Edward Ireland</u>			12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u>		
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY No. <u>None</u>		17. INFORMANT AND ADDRESS <u>Otis Johnson, Ellicott City, Md</u>

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Bronchopneumonia</u>		<u>3 days</u>
Antecedent cause(s) (b) <u>491X</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>107</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-12, 1951, to 1-14, 1951, that I last saw the deceased alive on 1-14, 1951, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE George E. Buehler M.D. ADDRESS Ellicott City, Md. DATE SIGNED 1-14-51

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>1-17-51</u>	NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>	LOCATION (City, town, or county) (State) <u>Clarksville, Md</u>
DATE REC'D BY LOCAL REG. <u>Jan 15, 1951</u>	REGISTRAR'S SIGNATURE <u>John B. Loughran</u> <u>Pres B. E. L.</u>	24. FUNERAL DIRECTOR ADDRESS <u>F.C. Higinbotham, Ellicott City, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. 415



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0548

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dorsey</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Dorsey Rd</u>		STREET ADDRESS (If rural, give location) <u>Dorsey Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary Ann Reimann</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>18</u> (Year) <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr 30, 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	9. AGE last birthday <u>72</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Heberville, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Piel</u>		14. MOTHER'S MAIDEN NAME <u>Williamina Sarip</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mrs. C. P. Reimann, Dorsey Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) Acute coronary occlusion 1 day

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

932

(b) Chor Myocarditis 1 yr(c) arterial hypertension 10 yrsII. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION
Sanility

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Dec 27, 1949, to Jan 18, 1951, that I last saw the deceasedalive on Jan 6, 1951, and that death occurred at 5 a. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 20/51</u>	NAME OF CEMETERY <u>Salem Lutheran Church</u>	LOCATION (City, town, or county) <u>Catonsville 28, Md.</u>	(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/19/51</u>	REGISTRAR'S SIGNATURE <u>H.W. Hedrick</u>	24. FUNERAL DIRECTOR <u>Harry F. Witzke</u>	ADDRESS <u>4101 Edmondson Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 0590

The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH- COUNTY <u>Howard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Elkridge, (Rural)</u>	
TOWN <u>Elkridge</u>		TOWN <u>Elkridge, (Rural)</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 111 Montgomery Rd</u>		STREET ADDRESS (If rural, give location) <u>Box 111 Montgomery Rd</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Lucy Lavana</u>	<u>Richardson</u>	<u>Lucy</u>	<u>Richardson</u>
4. DATE OF DEATH	(Month)	(Day)	(Year)
<u>Jan 18</u>	<u>19</u>	<u>57</u>	<u>19</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
<u>Female</u>	<u>col</u>	<u>Married</u>	<u>Aug 11, 1878</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
<u>Domestic</u>	<u>housewife</u>	<u>Elkridge md</u>	<u>us</u>
13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	
<u>Elisiah Crowner</u>	<u>Amanda Powell</u>	<u>no</u>	
16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS	18. MEDICAL CERTIFICATION	
<u>none</u>	<u>Lavana Field</u>	<u>Box 111 Monty Rd</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

443x Immediate cause (a)	<u>AP of Larynx</u>	INTERVAL BETWEEN ONSET AND DEATH
93d Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	<u>Left Hemiplegia</u>	<u>3 da</u>
	<u>Chronic caputitis</u>	<u>5 mo</u>
	<u>arterial hypertension</u>	<u>3 yrs</u>

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
<u>none</u>	<u>none</u>	Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR?

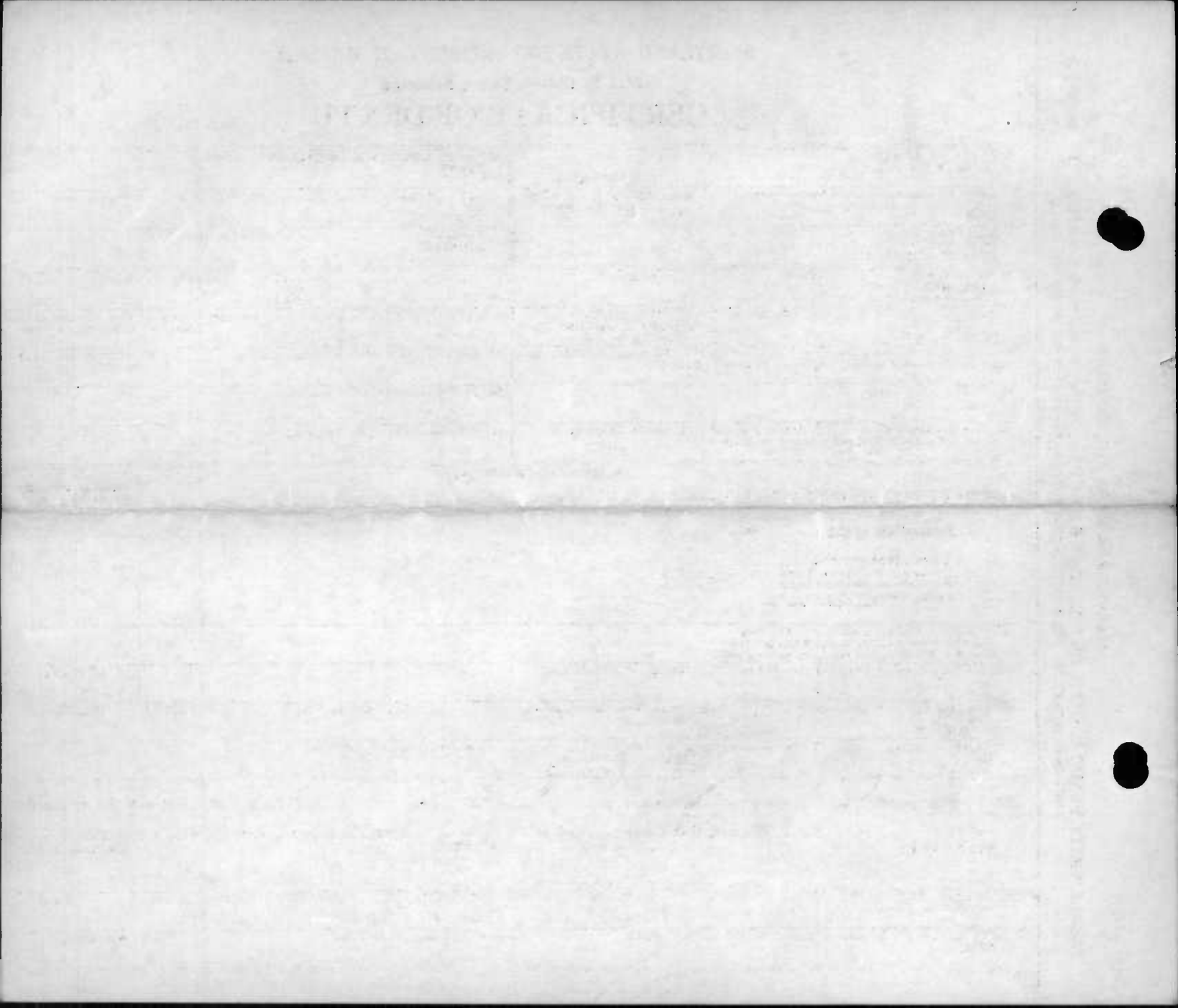
22. I hereby certify that I attended the deceased from Sept 5, 1950, to Jan 18, 1957, that I last saw the deceased alive on Jan 17, 1957, and that death occurred at 9:35 m., from the causes and on the date stated above.

SIGNATURE D. B. Brumbaugh (Degree or title) ADDRESS 3609 Main St Elkridge DATE SIGNED 1/19/57

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>1/21/1957</u>	<u>Arbutus mem. pk.</u>	<u>Balto md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>1/19/57</u>	<u>W. H. DeLoach</u>	<u>Holland Funeral Home</u>	<u>1671 W. Main Hill Ave.</u>

MARGIN RESERVED FOR BINDING

VS. A15



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 190

1. PLACE OF DEATH

County Howard
 City or town Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 75 yrs
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State MD County Howard
 City or town Elkridge
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5419 Main St
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

M. Gertrude Rodgers

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed
 6.(b) Name of husband or wife Harris E. Rodgers
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Nov 14, 1874
 8. AGE: Years 76 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Odenton, Md.
 (Town, county, and state)
 10. Usual occupation house work
 11. Industry or business at home
 12. Name Geo. W. Crook
 13. Birthplace Elkridge, Md.
 14. Maiden name Sarah M. Lowman
 15. Birthplace Odenton, Md.

16. Informant Mr. Harris E. Rodgers
 Address 5419 Main St. Elkridge, Md.
 17. burial Date thereof 1/9/51
 (Burial, cremation, or removal? Which?) (month) (day) (year)
 Cemetery or crematory Louisa Park Cem.
 Location 3802 Iggo Ave.
 18. Funeral director Paul Brown & Son
 Address 961 Spillius St.

19. Jan 6 19 51 (miss) E. Bidwell
 Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Jan 6 19 51 at 6:05 M
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 51 to Jan 6 19 51
 and that I last saw him alive on Jan 5 19 51
 Immediate cause of death acute coronary occlusion
 Due to hypertension 6 mo
Right Hemiplegia 6 days
General arterio-sclerosis 8 yrs
Hypertension 14 yrs
 Other conditions (Include pregnancy within 3 months of death)
 Major findings of operations 420.1
93d Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Dr. B. B. Brumbaugh
5609 Main St M. D. or other
Elkridge, Md. Date signed 1/6/51

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